A SOCIALLY ORIENTED PROGRAM OF RESTORATIVE CARE IN A GHETTO'S MUNICIPAL HOSPITAL

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A program such as this is based upon and must attract people who recognize advocacy as an essential component of the techniques of their disciplines. The director has to transmit to his staff an awareness that they care for a disenfranchised group without real political voice. Therapists administering physical modalities develop techniques and procedures that foster independent thought and decision making. Simultaneously, social workers encourage social awareness and political action. Health workers in the department do everything to facilitate the action and development of a constituency.

Modern society with its speed and trauma is producing a population of one out of 10 who are impaired. To be black or Hispanic adds to the catastrophic burden of impairment. Rehabilitation literature is void of discussion of this challenging topic. Motoric presentations deluge students. The many available texts instruct the student in the training methods for strength, endurance, skill, and other procedures easily demonstrable in the therapy area. For example: "An elderly man with progressive disease who lives on the fourth floor of a walk up apartment, with an aged wife—dependent on public assistance—will overwhelm and dismay the student of restorative care if he/she dares or cares to consider the patient from a social aspect."

Our patient load is drawn from a 4 1/2 square mile area inhabited by approximately half a million blacks and Hispanics. The rubble-strewn lots that juxtapose decaying brownstones are gradually being replaced by public housing, an endless row and stack of identical cubicles, hallways filled with the smell of urine and garbage. The population decreases as the young angry

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blacks, in a continuous struggle for survival in "the Man's" world, move away to battle with a resistant and hostile suburb. Left behind is a group of crushed, confused coloreds combined with a population of chronic alcoholics or drug addicts. The result is an unusual subset of people whose impairments demand of the carers initiative and creative therapeutic planning.

The base for inpatient or ambulatory restorative care is nursing that defies a traditional role. Rehabilitation applicants are referred from other departments in the hospital or health services within the community. They are evaluated by a nurse and not by a physician. This requires a nurse with extensive clinical experience and imposing academic qualifications.

The nurse's criterion: A patient with a disorder whose course calls for restorative intervention. The nurse is not deterred by disposition problems, promise of progression, or multiple diseases. If the patients are already under medical care, they may require better definition of their disorders or initiation of care or unrecognized diseases. It is not unusual for the nurse to admit patients with the expectation that their complicating disorders will be cared for by the appropriate medical discipline.

The professional disciplines involved are combined with the concomitant use of rehabilitation technicians and case aides drawn from the community. These lay people have undergone educational programs that orient them to multiple disease processes prevalent in this community, including basic services required for clinical management.

The multidisciplinary planning group, working with inpatients and occasional outpatients with complicated dispositions, is traditionally headed by the physiatrist. Operationally, the group is led by the discipline carrying the greatest responsibility for dealing with the patients' motor deficit. After some discussion, the city's corporation counselor approved the participation of the patient in the planning group—who better to focus the group on the problems and goals than a patient! Physical and occupational therapy are particularly motor-oriented. It is attitude and sensitivity, awareness of environmental obstruction to successful performance, that must be uppermost in the goals of the therapeutic program.

Great emphasis is placed on modification of the patients' environments to enable them to cope. All disciplines modify their therapy according to the findings of home visits and knowledge of patients' street life and personal goals. Here we see a curious positive. The environment, hostile to the successful function of normal individuals, is more easily modified by our agency. Hallways without lights, faulty elevators, and broken floors can be corrected when appropriate city agencies are brought to bear on recalcitrant

landlords. Caring physicians, therapists, social workers, and even patient groups function as advocates of the law. The home visit is emphasized.

Self-care skills are taught in occupational therapy, with carryover by involvement of nursing, physical therapy, and the family or significant others. Notice the high level of our expectation: that the patient make use of skills acquired in the hospital to perform in a radically modified environment. We struggle constantly for modification.

In occupational therapy a new and unusual program has developed. The high incidence of burns in the winter months (the gas stove, the kerosene heater utilized all too frequently in heatless apartments of this community) have necessitated a burn-care program. Elastic compression masks, gloves, and trunkal garments to combat scarring, and postburn splinting techniques have come into use. The people with burns provide an excellent example of the importance of the environment. In a recent paper from this department* it was concluded that the poor elderly and the poor impaired who live in a structurally inadequate environment are at greater risk of incurring burns than the people around them.

Physical and occupational therapists have concluded that ambulatory clinic visits related to devices must be kept to a minimum. The initial clinic visit should be viewed as the first and last therapeutic contact. These people have other priorities and little time for repeated visits to clinics that offer no solutions to the social questions in their lives. Instructions must be given verbally, patiently, and combined with frequent use of diagrams. Written instructions should be kept to a minimum in a community where illiteracy is frequently encountered.

A 28-year-old right-handed, unmarried black woman, the mother of two young children, sustained a traction injury of the right brachial plexus. Among other impairments of the involved extermity was a wrist drop for which a dorsiflexion splint was prescribed to improve her hook and grip. After the device was fabricated she was instructed in its use and given a follow-up visit appointment in two weeks. On the day of her appointment she had to chose between a therapy visit and a "face-to-face" [meeting] with her welfare worker. She chose the latter and was given a new appointment. On that date she could find no babysitter. Another appointment was given. This time she had to go to the welfare office; her check had not come. She was not seen again regarding that splint.

Social work focuses on the provision of concrete services and bridging

*Brodzka, W., Thornhill, H.L., and Howard, S.: Burns: causes and risk factors. *Arch. Phys. Med. Rehabil. 66:*746-52, 1985.

the gap between the professional and the patient. All too often the program and the goals of the professional are strange, unintelligble, and do not jibe with the realities that confront the patient. The social worker, using miniconferences in the therapy areas and the nursing unit, functions as an interpreter. It is here rather than in pseudopsychiatric in-depth interviews concerned with the patient's progress in the stylized motoric program. This regime requires a high worker-to-patient ratio. But the infrequent institutionalization of patients cared for by this service demonstrates the human economy.

The physician providing care to the impaired child first of all is a pediatrician concerned with the family unit, the milieu in which the child develops, and the environment which denies the child stimuli to growth and development. The physiatric education of this unique pediatrician creates a most appropriate carer for the impaired child.

Goals are limited to small behavioral increments and few striking motor improvements occur, which prove so rewarding to the motorically oriented therapist.

Therapy in the area of psycholinguistics is another challenge. Management of a patient who did not have command of the written and spoken word prior to illness requires modification of conventional testing and treatment. Emphasis is placed on the spoken word combined with great use of diagrams, gestures, and repetition in the process of psychological management and language therapy. The family and significant others (including nursing) are also instructed in the treatment of such patients. The goal is speech, verbal and written communication at levels that the patient utilized during his pre-illness lifestyle. We do not seek to have our patient speak "the Man's" language if he did not speak that way before.

Remember, poverty isn't going anywhere.

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